

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0037168</u></p> <p><b>Facility Name:</b> <u>FRANKLIN GROVE NURSING CENTER, INC.</u></p> <p><b>Address:</b> <u>502 N. State Street</u> <u>Franklin Grove</u> <u>61031</u>  Number City Zip Code</p> <p><b>County:</b> <u>Lee</u></p> <p><b>Telephone Number:</b> <u>(815) 456-2374</u> <b>Fax #</b> <u>(815) 456-2381</u></p> <p><b>IDPA ID Number:</b> <u>36-3755778</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>June 28, 1991</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Print Name and Title) <u>Noshir Daruwalla, C.P.A.</u> (Firm Name &amp; Address) <u>FROST, RUTTENBERG &amp; ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p style="text-align: center;"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Print Name and Title) <u>Noshir Daruwalla, C.P.A.</u> (Firm Name & Address) <u>FROST, RUTTENBERG &amp; ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,620</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,666</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,286</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,941</u>	<u>7,218</u>	<u>1,176</u>	<u>12,335</u>	8
9	SNF/PED					9
10	ICF	<u>16,811</u>	<u>11,158</u>		<u>27,969</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,752</u>	<u>18,376</u>	<u>1,176</u>	<u>40,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.01%

D. How many bed-hold days during this year were paid by Public Aid?

84 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started April 1, 1991

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date April 1, 1991NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 19

and days of care provided

1,176Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, 1** # **0037168** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
<b>1</b>	<b>A. General Services</b>											
1	Dietary	209,506	9,964	6,608	226,078		226,078	(862)	225,216			1
2	Food Purchase		197,895		197,895		197,895	(902)	196,993			2
3	Housekeeping	127,298	87,155		214,453		214,453		214,453			3
4	Laundry	73,342	8,269		81,611		81,611		81,611			4
5	Heat and Other Utilities			107,444	107,444		107,444	(465)	106,979			5
6	Maintenance	66,734	31,019	10,875	108,628		108,628	(1,323)	107,305			6
7	Other (specify):*											7
<b>8</b>	<b>TOTAL General Services</b>	476,880	334,302	124,927	936,109		936,109	(3,552)	932,557			8
<b>9</b>	<b>B. Health Care and Programs</b>											
9	Medical Director			7,300	7,300		7,300		7,300			9
10	Nursing and Medical Records	1,097,453	18,917	1,056	1,117,426		1,117,426		1,117,426			10
10a	Therapy	53,776		575	54,351		54,351		54,351			10a
11	Activities	75,483	1,829		77,312		77,312		77,312			11
12	Social Services	13,944			13,944		13,944		13,944			12
13	Nurse Aide Training			375	375		375		375			13
14	Program Transportation											14
15	Other (specify):*											15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	1,240,656	20,746	9,306	1,270,708		1,270,708		1,270,708			16
<b>17</b>	<b>C. General Administration</b>											
17	Administrative	92,493		180,000	272,493		272,493	(39,795)	232,698			17
18	Directors Fees											18
19	Professional Services			111,668	111,668		111,668	(72,959)	38,709			19
20	Dues, Fees, Subscriptions & Promotions			18,261	18,261		18,261	(3,214)	15,047			20
21	Clerical & General Office Expenses	175,319	23,328	20,534	219,181		219,181	45,711	264,892			21
22	Employee Benefits & Payroll Taxes			286,757	286,757		286,757		286,757			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,880	1,880		1,880	235	2,115			24
25	Other Admin. Staff Transportation			5,351	5,351		5,351	2,142	7,493			25
26	Insurance-Prop.Liab.Malpractice			60,215	60,215		60,215	32	60,247			26
27	Other (specify):*							12,250	12,250			27
<b>28</b>	<b>TOTAL General Administration</b>	267,812	23,328	684,666	975,806		975,806	(55,598)	920,208			28
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,985,348	378,376	818,899	3,182,623		3,182,623	(59,150)	3,123,473			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FRANKLIN GROVE NURSING CENTER, INC.

0037168

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V  
LINE #

22 EMPLOYEE BENEFITS

2 FOOD

To reclass cost of employee meals from raw food to employee benefits

33 REAL ESTATE TAX

19 PROFESSIONAL FEES

To reclass cost of appealing real estate taxes

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.** #0037168 Report Period Beginning: 01/01/00 Ending: 12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	Depreciation			15,659	15,659		15,659	90,125	105,784			30
31	Amortization of Pre-Op. & Org.							4,810	4,810			31
32	Interest			1,522	1,522		1,522	(1,403)	119			32
33	Real Estate Taxes			39,772	39,772		39,772	3,098	42,870			33
34	Rent-Facility & Grounds			398,574	398,574		398,574	(398,574)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			455,527	455,527		455,527	(301,944)	153,583			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,586	42,451	72,037		72,037	(27)	72,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		29,586	108,881	138,467		138,467	(27)	138,440			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,985,348	407,962	1,383,307	3,776,617		3,776,617	(361,121)	3,415,496			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,959)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	44,478	30		9
10	Interest and Other Investment Income	(105,353)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(902)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(415)	21		18
19	Entertainment				19
20	Contributions	(2,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,311)	21		24
25	Fund Raising, Advertising and Promotional	(405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,006)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,337)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,710)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(282,411)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (282,411)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (361,121)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS  
FRANKLIN GROVE NURSING CENTER, INC.

Page 5A

Report Period Beginning: 0037168  
Ending: 01/01/00  
12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$	6 1
2	FRANKLIN GROVE ASSOC. STATE REPL. TAX	(2,705)	21 2
3	TRUST FEES	(250)	20 3
4	REPAIR & MAINT. CAPITALIZED	(2,321)	6 4
5	NON-CARE ASSET DEPRECIATION EXPENSE	(107)	30 5
6	MISC. INCOME	(484)	21 6
7	AUTO EXPENSE	(241)	25 7
8	LEGAL FEES (COLLECTIONS)	(427)	19 8
9	TO BALANCE CREDIT	2,385	36 9
10	ILLINOIS COUNCIL LTC	(187)	20 10
11			11
12			12
13			13
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87			87
88			88
89			89
90	Total	(4,337)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(862)							(862)	1
2	Food Purchase	(902)											(902)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,959)		1,494									(465)	5
6	Maintenance	(2,321)		998									(1,323)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(5,182)</b>		<b>2,492</b>		<b>(862)</b>							<b>(3,552)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													16
	<b>C. General Administration</b>													
17	Administrative			(39,795)									(39,795)	17
18	Directors Fees													18
19	Professional Services	(427)		(81,535)	9,003								(72,959)	19
20	Fees, Subscriptions & Promotions	(3,342)		128									(3,214)	20
21	Clerical & General Office Expenses	(10,921)	2,705	53,918	9								45,711	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			235									235	24
25	Other Admin. Staff Transportation	(241)		2,383									2,142	25
26	Insurance-Prop.Liab.Malpractice			32									32	26
27	Other (specify):*			12,250									12,250	27
28	<b>TOTAL General Administration</b>	<b>(14,931)</b>	<b>2,705</b>	<b>(52,384)</b>	<b>9,012</b>								<b>(55,598)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(20,113)</b>	<b>2,705</b>	<b>(49,892)</b>	<b>9,012</b>	<b>(862)</b>							<b>(59,150)</b>	<b>29</b>





Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00**

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST INCOME	\$ 181,294	FRANKLIN GROVE ASSOCIATES		\$	\$ (181,294)	1
2	V	34	RENTAL INCOME	398,574	FRANKLIN GROVE ASSOCIATES			(398,574)	2
3	V	36	GAIN ON PARTNERSHIP	2,385	FRANKLIN GROVE ASSOCIATES			(2,385)	3
4	V	32	INTEREST EXPENSE		FRANKLIN GROVE ASSOCIATES		235,037	235,037	4
5	V								5
6	V	30	DEPRECIATION EXPENSE		FRANKLIN GROVE ASSOCIATES		42,352	42,352	6
7	V	31	AMORTIZATION EXPENSE		FRANKLIN GROVE ASSOCIATES		4,810	4,810	7
8	V	21	REPLACEMENT TAX		FRANKLIN GROVE ASSOCIATES		2,705	2,705	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 582,253			\$ 284,904	\$ * (297,349)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 1,494	\$ 1,494 15
16	V	6 REPAIRS AND MAINT.		S.W. MANAGEMENT		998	998 16
17	V	19 PROFESSIONAL FEES		S.W. MANAGEMENT		3,665	3,665 17
18	V	20 FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT		128	128 18
19	V	21 CLERICAL AND GENERAL		S.W. MANAGEMENT		53,918	53,918 19
20	V	24 EDUCATION AND SEMINARS		S.W. MANAGEMENT		235	235 20
21	V	25 TRANSPORTATION		S.W. MANAGEMENT		2,383	2,383 21
22	V	26 INSURANCE - PROPERTY		S.W. MANAGEMENT		32	32 22
23	V	27 PAYROLL TAXES		S.W. MANAGEMENT		9,518	9,518 23
24	V	30 DEPRECIATION		S.W. MANAGEMENT		3,402	3,402 24
25	V	32 INTEREST EXPENSE		S.W. MANAGEMENT		2,859	2,859 25
26	V	33 REAL ESTATE TAXES		S.W. MANAGEMENT		3,098	3,098 26
27	V	0				0	
28	V	0					
29	V	0					
30	V	17 SALARY - SHELDON WOLFE		S.W.MANAGEMENT		42,205	42,205 30
31	V	17 SALARY - RONNIE KLEIN		S.W.MANAGEMENT		8,000	8,000 31
32	V	27 EMP. BEN.-SHELDON WOLFE		S.W.MANAGEMENT		1,233	1,233 32
33	V	27 EMP. BEN.-RONNIE KLEIN		S.W.MANAGEMENT		1,499	1,499 33
34	V	0					
35	V	19 HOME OFFICE/MGMNT. FEES	85,200	S.W.MANAGEMENT			(85,200) 35
36	V	17 MANAGEMENT FEES	90,000	S.W.MANAGEMENT			(90,000) 36
37	V						
38	V						
39	Total		\$ 175,200			\$ 134,667	\$ * (40,533) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 PROFESSIONAL FEES	\$	SFO ASSOCIATES	100.00%	\$ 9,003	\$ 9,003	15
16	V	21 CLERICAL & GENERAL		SFO ASSOCIATES	100.00%	9	9	16
17	V	32 INTEREST		SFO ASSOCIATES	100.00%	248,178	248,178	17
18	V	0				0		18
19	V	0				0		19
20	V	32 INTEREST	200,830	SFO ASSOCIATES	100.00%	0	(200,830)	20
21	V	0				0		21
22	V	0				0		22
23	V	0				0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0						35
36	V							36
37	V							37
38	V							38
39	Total		\$ 200,830			\$ 257,190	\$ * 56,360	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 MEDICARE A - SUPPLEMENT	133	S & E MEDICAL SUPPLY	100.00%	106	\$	(27)
16	V	1 DIETARY SUPPLEMENT	8,624	S & E MEDICAL SUPPLY	100.00%	7,762		(862)
17	V							
18	V							
19	V							
20	V							
21	V							
22	V							
23	V							
24	V							
25	V							
26	V							
27	V							
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 8,757			\$ 7,868	\$ *	(889)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	10 PHARM. CONSULTANT	\$ 1,056	PHARMCOR	100.00%	\$ 1,056		15
16	V	10 PHARM. NON-REBILLABLE	2,907	PHARMCOR	100.00%	2,907		16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,963			\$ 3,963	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER,** # **0037168** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**VII. RELATED PARTIES (continued)**

**C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.**

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	OWNER	Administrative	31.74	SEE ATTACHED	4	6.67%	SW MGMT	\$ 42,205	17-7	1
2	RONNIE KLEIN	OWNER	Administrative	15.83	SEE ATTACHED	8	13.33%	SW MGMT	8,000	17-7	2
3	RONNIE KLEIN	OWNER	Administrative	15.83	SEE ATTACHED	8	13.33%	Fees-Facility	90,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 140,205		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S.W. MANAGEMENT  
 Street Address 7434 N. SKOKIE BLVD.  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 982-2300  
 Fax Number ( 847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	H. O. / MGMT. FEE INC.	1,673,600	10	\$ 14,270	\$	175,200	\$ 1,494	1
2	6	REPAIRS AND MAINT.	H. O. / MGMT. FEE INC.	1,673,600	10	9,537		175,200	998	2
3	19	PROFESSIONAL FEES	H. O. / MGMT. FEE INC.	1,673,600	10	35,007		175,200	3,665	3
4	20	FEES, SUBSCRIPTIONS, DUES	H. O. / MGMT. FEE INC.	1,673,600	10	1,218		175,200	128	4
5	21	CLERICAL AND GENERAL	H. O. / MGMT. FEE INC.	1,673,600	10	515,053	446,676	175,200	53,918	5
6	24	EDUCATION AND SEMINARS	H. O. / MGMT. FEE INC.	1,673,600	10	2,244		175,200	235	6
7	25	TRANSPORTATION	H. O. / MGMT. FEE INC.	1,673,600	10	22,760		175,200	2,383	7
8	26	INSURANCE - PROPERTY	H. O. / MGMT. FEE INC.	1,673,600	10	309		175,200	32	8
9	27	PAYROLL TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	90,916		175,200	9,518	9
10	30	DEPRECIATION	H. O. / MGMT. FEE INC.	1,673,600	10	32,499		175,200	3,402	10
11	32	INTEREST EXPENSE	H. O. / MGMT. FEE INC.	1,673,600	10	27,315		175,200	2,859	11
12	33	REAL ESTATE TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	29,591		175,200	3,098	12
13										13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	10	633,071	633,071	4	42,205	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000	8	8,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	10	18,497		4	1,233	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	11,246		8	1,499	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,503,533	\$ 1,139,747		\$ 134,667	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

SFO ASSOCIATES

Street Address

7434 N. SKOKIE BLVD.

City / State / Zip Code

SKOKIE, IL 60077

Phone Number

( 847) 982-2300

Fax Number

( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	\$ 20,901	\$	2,800,000	\$ 9,003	1
2	21	CLERICAL & GENERAL	NOTE RECEIVABLE	6,500,000	3	20		2,800,000	9	2
3	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	576,127		2,800,000	248,178	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 597,048	\$		\$ 257,190	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

S & E MEDICAL SUPPLY

Street Address

3100 COMMERCIAL AVENUE

City / State / Zip Code

NORTHBROOK, IL 60062

Phone Number

( 847) 982-9300

Fax Number

( 847) 982-2304

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	MEDICARE A SUPPLEMENTS	Direct Allocation		\$	\$		\$ 106	1
2	1	DIETARY SUPPLEMENTS	Direct Allocation					7,762	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 7,868	25



Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

PHARMCOR

Street Address

3116 S OAK PARK

City / State / Zip Code

BERWYN, IL 60402

Phone Number

( 847) 982-9300

Fax Number

( 847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	PHARMCOR	Direct Allocation		\$	\$		\$ 2,112	1
2	10	PHARMCOR	Direct Allocation					2,907	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 5,019	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, I**# **0037168**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	ST Note Payable - Insurance											1,522	6	
7													7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	1,522	9
	B. Non-Facility Related*													
10	Supplemental Schedule											(1,403)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	(1,403)	14
15	TOTALS (line 9+line14)						\$		\$			\$	119	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC**# **0037168**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	Interest Income - Facility	X					\$					\$ (105,353)	1
2													2
3	Alloc. Franklin Grove Assoc:	X											3
4	Interest Income											(181,294)	4
5	Interest Expense Non-SFO											34,207	5
6	Interest Expense SFO											200,830	6
7													7
8													8
9													9
10	Alloc. SFO Associates	X											10
11	Interest Income											(200,830)	11
12	Interest Expense											248,178	12
13													13
14													14
15													15
16	SW Management	X										2,859	16
17													17
18													18
19													19
20													20
21							\$		\$			\$ (1,403)	21



Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>40,404</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>42,208</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>1,804</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>41,066</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$                      For 19                      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>42,870</b>	7

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<b>34,818</b>	8
	1996	<b>36,816</b>	9
	1997	<b>38,353</b>	10
	1998	<b>38,480</b>	11
	1999	<b>39,110</b>	12

  

<b>R.E. Taxes Accrual 2000:</b>			
<b>39,110 x 1.05 = \$41,066</b>			
<b>Allocation from SW Mgmt R.E. Taxes - \$3,098 is included on line 2 above</b>			

  

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Facility Name &amp; ID Number FRANKLIN GROVE NURSING CENTER, INC.

# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,868 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living (45 Units)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO  
If so, please complete the following:

1. Total Amount Incurred: 150,339 2. Number of Years Over Which it is Being Amortized: 30

3. Current Period Amortization: 4,810 4. Dates Incurred: August 1994

Nature of Costs: SW MANAGEMENT ALLOC.

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>		<u>1991</u>	\$ <u>36,205</u>	1
2					2
3	<u>TOTALS</u>			\$ <u>36,205</u>	3

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1991		\$ 1,334,100	\$ 42,352	35	\$ 38,117	\$ (4,235)	\$ 362,112	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1991		6,395	203	20	320	117	2,907	9
10	Various		1992		29,415	1,737	20	1,471	(266)	12,626	10
11	Various		1993		47,512	1,340	20	2,376	1,036	19,600	11
12	Various		1994		17,652	297	20	883	586	5,939	12
13	Various		1995		10,809	164	20	541	377	3,029	13
14	CHASSIS		1996				20				14
15	CHASSIS		1996				20				15
16	WALLPAPER		1997		689	80	20	34	(46)	108	16
17	CARPET		1997		4,500		20	225	225	750	17
18	LOCKS & LABOR		1997		4,491	115	20	225	110	863	18
19	PAVING		1997		15,387	395	20	769	374	2,627	19
20	SIDEWALK		1997		7,914	609	20	396	(213)	2,221	20
21	LANDSCAPING		1997		1,750	135	20	88	(47)	308	21
22	HEAT EXCHANGER		1997		4,996	624	20	250	(374)	875	22
23	WALLPAPER		1997		1,252	144	20	63	(81)	200	23
24											24
25	PAGE 12-1 REP TOTALS				57,167	1,713		1,816	103	7,976	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				129,210	4,902		6,404	1,502	13,483	35
36	TOTAL (lines 4 thru 35)				\$ 1,673,239	\$ 54,810		\$ 53,978	\$ (832)	\$ 435,624	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		WALLPAPER		1997	812	93	20	41	(52)	130	9
10		SNOW MELT SYSTEM		1997	2,200	275	20	110	(165)	532	10
11		BACK ROOM & NURSING		1997	8,270	953	20	414	(539)	2,275	11
12		WALLPAPER		1997	1,037	119	20	52	(67)	165	12
13		GAS WATER HEATER		1997	2,493	311	20	125	(186)	438	13
14		NEW GENERATOR		1998	65,000	1,667	20	3,250	1,583	5,820	14
15		DOORS WITH PLASTIC		1998	11,052	283	20	553	270	895	15
16		DOOR WITH PLASTIC		1998	9,760	250	20	488	238	790	16
17		RETROAIRE CLASSIC		1998	2,152	413	20	108	(305)	647	17
18		CIRCUIT BREAKER		1999	21,000	538	20	1,050	512	1,488	18
19		AIR CONDITIONERS		1999	807		20	40	40	63	19
20		RETROAIRE CHASSIS		1999	2,306		20	115	115	182	20
21		RETROAIRE CHASSIS		2000	2,321		20	58	58	58	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 129,210	\$ 4,902		\$ 6,404	\$ 1,502	\$ 13,483	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
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25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5			1995	SW MGMT	47,112	1,208	35	1,346	138	6,266	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC SW MGMT			1995	4,834	250	20	289	39	1,279	9
10	ALLOC SW MGMT			1996	844	22	20	42	20	151	10
11	ALLOC SW MGMT			1997	1,216	152	20	87	(65)	197	11
12	ALLOC SW MGMT			1998	837	21	20	42	21	73	12
13	ALLOC SW MGMT			1999	2,324	60	20	10	(50)	10	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 57,167	\$ 1,713		\$ 1,816	\$ 103	\$ 7,976	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CENTER, INC.# 0037168

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC. # 0037168**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 518,199	\$ 4,985	\$ 51,784	\$ 46,799		\$ 410,034	37
38	Current Year Purchases	1,511	1,511	22	(1,489)		22	38
39	Fully Depreciated Assets	1,745					1,745	39
40								40
41	<b>TOTALS</b>	\$ 521,455	\$ 6,496	\$ 51,806	\$ 45,310		\$ 411,801	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,230,899	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 61,306	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 105,784	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 44,478	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 847,425	51

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53	BILL NIGUE	4,200	108	1,172	53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$ 4,200	\$ 108	\$ 1,172	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



FRANKLIN GROVE NURSING CENTER, INC.  
0037168  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
FRANKLIN GROVE NURSING CENTER	338,012	4,806	33,807	29,001	242,579
FRANKLIN GROVE ASSOCIATES	171,000		17,100	17,100	162,450
SW MANAGEMENT	9,187	179	877	698	5,005
TOTALS	518,199	4,985	51,784	46,799	410,034

**LINE 29: CURRENT YEAR**

FRANKLIN GROVE NURSING CENTER					
FRANKLIN GROVE ASSOCIATES					
SW MANAGEMENT	1,511	1,511	22	(1,489)	22
TOTALS	1,511	1,511	22	(1,489)	22

**LINE 30: FULLY DEPRECIATED**

FRANKLIN GROVE NURSING CENTER	1,745				1,745
FRANKLIN GROVE ASSOCIATES					
SW MANAGEMENT					
TOTALS	1,745				1,745

**TOTALS (Should Tie to Totals on Page 13)**

FRANKLIN GROVE NURSING CENTER	339,757	4,806	33,807	29,001	244,324
FRANKLIN GROVE ASSOCIATES	171,000		17,100	17,100	162,450
SW MANAGEMENT	10,698	1,690	899	(791)	5,027
TOTALS	521,455	6,496	51,806	45,310	411,801

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

**01/01/00**Ending: **12/31/00****XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES☒ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2001 \$ \_\_\_\_\_

13. \_\_\_\_\_/2002 \$ \_\_\_\_\_

14. \_\_\_\_\_/2003 \$ \_\_\_\_\_

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**  
 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

# **0037168** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="checked" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input checked="checked" type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 375	\$	\$ 375
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 375	\$	\$ 375
10	SUM OF line 9, col. 1 and 2 (e)	\$ 375			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 9,774	\$		\$ 9,774	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,140			2,140	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,537			30,537	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				26,423		26,423	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	**SEE SUPPLEMENTAL									
13	Other (specify): SCHEDULE**						3,136		3,136	13
14	TOTAL			\$		\$ 42,451	\$ 29,559	\$	72,010	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	100
2 Enteral Expense	106
3 Oxygen	830
4 Laboratory	2,100
5	
6	
7	
8	
9	
10	
	<u>3,136</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u></u>

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 351,713	\$ 353,713	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	304,191	304,191	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	26,700	26,700	6
7 Other Prepaid Expenses	2,032	2,032	7
8 Accounts Receivable (owners or related parties)		2,387,106	8
9 Other(specify): See supplemental schedule	1,499,118	1,111,346	9
<b>TOTAL Current Assets</b>			
10 (sum of lines 1 thru 9)	\$ 2,183,754	\$ 4,185,088	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		36,205	13
14 Buildings, at Historical Cost		1,334,101	14
15 Leasehold Improvements, at Historical Cos	195,139	316,139	15
16 Equipment, at Historical Cost	440,669	490,669	16
17 Accumulated Depreciation (book methods)	(466,626)	(1,038,205)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):		112,942	22
23 Other(specify): See supplemental schedule			23
<b>TOTAL Long-Term Assets</b>			
24 (sum of lines 11 thru 23)	\$ 169,182	\$ 1,251,851	24
<b>TOTAL ASSETS</b>			
25 (sum of lines 10 and 24)	\$ 2,352,936	\$ 5,436,939	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 66,209	\$ 66,209	26
27 Officer's Accounts Payable		2,283,077	27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	42,818	42,818	30
31 Accrued Taxes Payable (excluding real estate taxes)	4,985	4,985	31
32 Accrued Real Estate Taxes(Sch.IX-B)	41,066	41,066	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See supplemental schedule	290	290	36
37			37
<b>TOTAL Current Liabilities</b>			
38 (sum of lines 26 thru 37)	\$ 155,368	\$ 2,438,445	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 See supplemental schedule			43
44			44
<b>TOTAL Long-Term Liabilities</b>			
45 (sum of lines 39 thru 44)	\$	\$	45
<b>TOTAL LIABILITIES</b>			
46 (sum of lines 38 and 45)	\$ 155,368	\$ 2,438,445	46
<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,197,568	\$ #REF!	47
<b>TOTAL LIABILITIES AND EQUITY</b>			
48 (sum of lines 46 and 47)	\$ 2,352,936	\$ #REF!	48

\*(See instructions.)

## STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name &amp; ID Number FRANKLIN GROVE NURSING CENTER, INC.

# 0037168

Report Period Beginning: 01/01/00

Ending:

12/31/00

## SUPPLEMENTAL SCHEDULE OF OTHER ASSETS &amp; LIABILITIES

As of 12/31/00

## OTHER CURRENT ASSETS:

Real Estate Tax Escrow

EMPLOYEE LOANS

DUE FROM FRANKLIN GROVE INC

SHORT TERM LOAN EXCHANGE

DUE FROM THE MEADOWS

ACCRUED RETIREMENT

Amount

Amount

17,000

17,000

387,772

288,749

288,749

805,310

805,310

287

287

1,499,118

1,111,346

## OTHER CURRENT LIABILITIES:

Accrued Expenses

Accrued R. E. Tax -

Non Care Property

DUE FROM STATE

Amount

Amount

290

290

290

290

## OTHER NON CURRENT ASSETS:

Construction In Progress

Utility Deposit

Loan Costs Less Amortization

112,942

112,942

## OTHER NON CURRENT LIABILITIES:

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,813,809</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,813,809</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>625,739</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(241,980)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 383,759</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 2,197,568</b>	<b>24</b>

\* This must agree with page 17, line 47.



Facility Name & ID Number	FRANKLIN GROVE NURSING CENT#	0037168	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	1,813,809
----------------------------	-----------

Adjustments:

-

-

-

Total adjustments

-

Balance - Beginning of Year

1,813,809

Equity(Deficit) from Page 17 Col 1

2,197,568

Related Party

Equity(Deficit)

503577

Income

297349

800,926

Combined Equity - End of Year

2,998,494

Facility Name &amp; ID Number FRANKLIN GROVE NURSING CENTER, INC. # 0037168

Report Period Beginning: 01/01/00

Ending: 12/31/00

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,236,563	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,236,563	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	24,968	6
7	Oxygen	5,160	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 30,128	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,264	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,564	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 29,828	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	105,353	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 105,353	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	484	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 484	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,402,356	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	936,109	31
32	Health Care	1,270,708	32
33	General Administration	975,806	33
	<b>B. Capital Expense</b>		
34	Ownership	455,527	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	72,037	35
36	Provider Participation Fee	66,430	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,776,617	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	625,739	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 625,739	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	
2 Misc. Income (Finance Charges) Adjusted out on p. 5	484
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	484

Facility Name &amp; ID Number FRANKLIN GROVE NURSING CENTER, INC.

# 0037168

Report Period Beginning: 01/01/00

Ending:

12/31/00

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 42,274	\$ 20.32	1
2	Assistant Director of Nursing	2,000	2,080	36,005	17.31	2
3	Registered Nurses	3,128	3,280	57,778	17.62	3
4	Licensed Practical Nurses	19,858	21,251	339,997	16.00	4
5	Nurse Aides & Orderlies	63,417	65,493	621,399	9.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,252	5,517	53,776	9.75	8
9	Activity Director					9
10	Activity Assistants	7,016	7,223	75,483	10.45	10
11	Social Service Workers	1,193	6,325	13,944	2.20	11
12	Dietician					12
13	Food Service Supervisor	3,286	3,294	47,531	14.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,621	23,439	161,975	6.91	15
16	Dishwashers					16
17	Maintenance Workers	5,785	6,030	66,734	11.07	17
18	Housekeepers	17,423	18,343	127,298	6.94	18
19	Laundry	9,141	9,616	73,342	7.63	19
20	Administrator	2,000	2,080	92,493	44.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,525	11,998	175,319	14.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	175,645	188,049	\$ 1,985,348 *	\$ 10.56	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	110	\$ 6,608	1-3	35
36	Medical Director	112	7,300	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	22	1,056	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	16	575	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	260	\$ 15,539		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
JILL GEE	Administrator	0%	\$ 92,493	Workers' Compensation Insurance		\$ 36,418	IDPH License Fee	\$ 400	
				Unemployment Compensation Insurance		13,431	Advertising: Employee Recruitment	8,810	
				FICA Taxes		150,833	Health Care Worker Background Check	420	
				Employee Health Insurance		75,720	(Indicate # of checks performed 42 )		
				Employee Meals			Promotional Advertising	405	
				Illinois Municipal Retirement Fund (IMRF)*			Illinois Council on LTC	4,849	
				Employee Benefits		5,426	Dues & Subscriptions	40	
				Holiday Expense		4,929	Licenses, Inspections & Permits	400	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									
					</				

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

[illegible]

Facility Name & ID Number **FRANKLIN GROVE NURSING CENTER, INC.**# **0037168**Report Period Beginning: **01/01/00**Ending: **12/31/00****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC -\$4,849
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,429  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.



Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

#### **Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

#### **Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw